Compliance Evaluation

Broughton Hospital

Date of Site Visit: November 5-6, 2007

Date of Report: November 13, 2007

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Code for reading this Evaluation

C = Compliance. Hospital has substantially complied with the requirement.

SC = Significant compliance. Considerable compliance has been achieved on the key components of the requirement, but refinements remain to be completed.

PC = Partial compliance. Hospital has made reasonable gains toward being in compliance with the requirement, but substantial work remains.

NC = Not in compliance. Hospital has made inadequate progress towards being in compliance.

All four measures reflect current outcomes of Hospital's work and are neither a measure of intent nor of effort. In fact, minimal effort in one area might achieve compliance on one item while significant effort in another may still leave the Hospital rated not in compliance on that item.

Font in this Evaluation.

Italics. Items in italics represent those found to be in compliance at the time of prior evaluation.

Bold Face. Items in bold face reflect findings from this evaluation.

DATA BASE

Documents

Admission/Discharge

List of patients with 3 or more BH admissions in 2007
List of patients with 10 or more BH admissions in lifetime
BH Average Daily Census, FY 2000-FY 2007
BH Total Admissions, FY 2000-FY 2007
Preliminary Discharge Summary/Aftercare Plan with Discharge/Visit Order Sheet and
Psychiatrists Discharge
Progress Note

1058953	11-2-07	W6
0276445	11-2-07	W7
1084250	11-2-07	W8
1084507	11-2-07	W4
1076744	11-2-07	W6
0259684	11-2-07	105L
0276286	11-2-07	W3
1084963	11-2-07	105L
1085047	11-2-07	104L
1085000	11-2-07	
1085044	11-2-07	
1045141	11-2-07	
1047117	11-2-07	
1080199	11-5-07	

Assessments

Psychiatric-Admissions

1083691	9-9-07
0290575	9-27-07
1063419	9-27-07
0276445	9-27-07
1083493	9-1-07
1083611	9-6-07
1025228	9-21-07
1058953	9-21-07
1083964	9-19-07
1079214	9-20-07

Psychiatric-Annual

1030209	8-6-06
0268193	8-10-05
0278606	9-7-06
0264101	8-10-92

0158900 9-17-05

Treatment Plans

With Behavioral Treatment Plans

0289693	update	10-15-07
1083139	update	10-2-07
0395576	update	10-9-07
1081611	comprehensive	10-9-07

One comprehensive Treatment Plan per Team

0161128	9-18-07	AA W3
0395419	9-13-07	AA W4
1070189	9-5-07	AA W7
1038851	9-28-07	AA W4
1059992	9-24-07	W 8
1079703	10-16-07	Gero W14
1083714	9-14-07	Gero W15
1051415	9-21-07	Adol W18
1083493	9-6-07	Adol W20F
1027652	9-4-07	Deaf W22
0287691	9-26-07	PR WS
1074350	9-19-07	PR WT
0396955	10-2-07	PR WU
1067019	9-18-07	PR WW
1071220	9-26-07	Med 103M

One update per Team

1083499	9-27-07	AA W3
8200125	9-14-07	AA W4
0717230	9-5-07	AA W6
0282366	9-18-07	AA W7
1083469	9-26-07	AA W8
0272344	9-25-07	Gero W14
0939355	9-13-07	Gero W15
1056943	9-10-07	Adol W18
1002350	9-6-07	Adol W20F
1027652	9-13-07	Deaf W22
0287703	9-19-07	PR WS
1062469	9-26-07	PR WT
1059469	9-11-07	PR WU
1082378	9-27-07	PR WV
0248342	9-18-07	PR WW
1083501	10-3-07	Med 103M

P/P: Treatment Planning Process, July 2, 2007

Medication

Copies of all orders for STAT psychiatric medications with accompanying MD and RN progress notes, last two weeks in September 2007, first two weeks in October 2007.
Active patients on antipsychotics, October 24, 2007
Report of multiple antipsychotics, October 24, 2007
Patients on routine benzodiazepines and rationale for use, October 22, 2007
P/P: medication Orders/Timeframes for Administration, May 16, 2007
P&T Annual Aggregate Data Review, Fiscal Year 2006-2007
All patients on clozapine and any other antipsychotic medication patient also takes, November 6, 2007

Medical

Patient deaths, January 1, 2006-October 24, 2007

Behavioral Interventions

Last five Behavioral Intervention Plans

1083139	10-19-07
0289693	10-1-07
1052689	10-5-07
0395576	10-15-07
1081611	10-12-07

Other Behavioral Intervention Plans

1074350	9-19-07

Sampling of Behavior Intervention progress notes following up on BIP's

Special Populations

Comprehensive Treatment Plan – Substance Use

MRN	Plan Date	Unit
1077246	9-11-07	Psych Rehab
0959273	9-20-07	Deaf
1083212	9-5-07	Adol
1030253	10-17-07	Adult Admit

Treatment Plan Update – substance use

0719301	10-17-07	Psych Rehab

Assessment and Treatment of Patients with co-Occurring Substance use Disorders on Adult Admission Division
Co-Occurring Disorders PSI Pathway Content
PSI Programming in Psychiatric Rehabilitation Division for Patients with Co-Occurring Substance use Disorders
List of BH inpatients with MR or Borderline IQ, October 24, 2007
HEARTS list

BH SW list

List of MR admissions, July 1-October 24, 2007

Medication Record (Orders, progress Notes, Consent) for last five MR admissions

1021059	10-21-07
0279075	10-19-07
1084683	10-15-07
1004345	10-15-07
1082522	10-9-07

Treatment Plans for Patients with MR

1052689	9-21-07	10-11-07	Impulse Control D/O Mild MR
1083699	9-10-07	9-12-07	Mood Dis vs IED Moderate MR
0282763	9-6-07	9-25-07	Psychotic d/O Impulse Control D/O Mild MR
0259679	10-9-07	10-17-07	Impulse Control D/O Severe MR
1081880	6-30-07	10-23-07	Impulse Control D/O Mild MR

PSI Programming in Adult Admission Division for Patients with Mental Retardation

PSI Programming in Psychiatric Rehabilitation Division for Patients with Mental Retardation

P/P: Substance-Related Disorders: Assessment and Treatment, March 29, 2006

PSR

Attendance sheets with STG's for all P-Division PSR groups, November 5, 2007, 13:10-14:10

Policies and Procedures (not listed elsewhere)

Safety Precautions, August 25, 2007

Medical Records, May 25, 2007

Record Entries, Quantitative, October 17, 2007

Forms

Substance Abuse Assessment

URICA (University of Rhode Island Change Assessment) Scale

Division A PSI Progress Notes

Division P PSI Progress Notes

QA/PI

Rate of successful PI submission, July 2006-June 2007

Division and Department Result, PIP's, July 2006-June 2007

BH PI Priorities/Goals, 2006-2007
Final Annual Goals Report, July 3, 2007
Patient Perception of Care
Family Perception of Care
Final Annual PI Goals Report, July 2, 2007
Data Management
Final Annual PI Goals Report, July 27, 2007
Physical Renovations
New Forensic Wards (February 1, 2008)
Final Annual PI Goals Report, undated
Individualized Treatment Planning System
Safety Management
Final Annual PI Goals Report, July 22, 2007
1:1 project
Final Annual PI Goals Report, July 27, 2007
Implementation of IPPS and Medicare Part D
Final Annual PI Goals Report, June 15, 2007
Survey readiness and culture of compliance
Comprehensive Organizational performance Improvement Plan, FY 2007-2008 Plan
QA/PI Indicators and results for 2007 for admissions and discharge
Patient Incident Reports, November 5, 2007

Minutes
Utilization Management Committee Meeting, June 5, October 2, 2007
Mortality Review Committee Meeting
June 9, 2006
January 12, March 9, August 10, 2007

Physical Plant
Life Safety Assessment, July 24, 2007
Monthly Walkthrough Inspection Report, monthly, January-September 2007

Staff Training
Training calendars, monthly, January-October 2007

Staffing
Retirees, 2007
Psychiatry positions, November 5, 2007
Nursing HPPD, October 15-31, 2007

External Documents

Center for Medicare & Medicaid Services
July 31-August 2, 2007 – Complaint Investigation
Statement of Deficiencies with Cover Letter (no date)

Corrective Action Plan and Attachments with Memo dated 8/21/07 – Acceptance of Corrective Action Plan

August 22-25, 2007 – Full Survey

Statement of Deficiencies with Cover Letter (no date)

Joint Commission (JCAHO)

April 16-18, 2007 – Full Survey

Requirements for Improvement

Correction Plan

September 6, 2007 – For Cause

(No Documentation Received as of September 11, 2007)

NC Surveys

Division of Facility Services – February 20-21, 2007 – Investigation

Division of Facility Services – April 9-10, 2007 – Alleged Abuse Unsubstantiated

On Site

Interviews

Seth Hunt, Hospital Director
Robi Baker, Acting Chief Regulatory Compliance
Jon Berry, Chief, Support Services
Vivian Streater, Director of Nursing
William F. Brown, III, Safety Director
Richard Lancaster, M.D., DMH/DD/SAS, Chief, Clinical Policy
Jerry McKee Pharm.D., Pharmacy Manager
Dixon Byrd, Assistant to Clinical Director
John Esse, Ph.D., Deputy Hospital Director
Reneé Brackett, Division Administrator, Psych Rehab
Wayne Braffman, Ph.D., Chief Psychologist Division A
Elizabeth Huddleston, Psy.D., Psychology Department Director
Charles Flagler, Psy.D., Senior Behavior Specialist
Donna McClellan, MSW, MR/MI Coordinator
Barbara R. Myers, Social Work Program Director
Stephanie Greer, Administrator, Adult Admissions
Tressa Hall, Specialty Service Division Administration
Stacie MacDonald, Staff Psychologist/Treatment Plan
Jennifer Bagley, Music Therapist (P)
Trina Butler, Vocational Services (P)
William Robertson, Chaplain
Greg Flanders, Vocational Services (P)
Lisa Cornet, RN Manager (S)

Medical Records

MRN	DOB	DOA	Unit (Ward)
0229610	5-29-36	10-30-07	S [Gero]
0272620	10-29-57	4-11-07	P (T)

1038851	7-7-83	9-20-07	P (W)
1043425	6-6-87	9-19-07	P
0278514	7-17-62	7-26-07	P (S)
1054739	6-5-81	12-14-04	P (U)
0395576	11-13-71	12-1-07	P (U)
1081880	7-16-61	6-30-07	P (U)
1084285	1-20-56	9-30-07	A (7)
1083528	9-12-46	9-6-07	A (3)
1059992	11-13-86	9-18-07	A (8)
0382950	4-27-63	5-1-06	S [Deaf] (22)
1081611	5-15-90	10-4-07	S [Adol] (20)
0259679	3-23-90	10-9-07	S [Adol] (18)
1079703	10-22-42	4-19-07	S [Gero] (14)
0953726	5-22-75	5-1-06	S [Deaf] (22)
0276445	10-11-59	9-27-07	Discharged
0977822	10-15-77	8-22-07	Discharged
1033322	10-27-70	10-1-07	Discharged
1004448	10-3-86	8-28-07	Discharged
1053311	9-30-85	9-25-07	Discharged

Death Reviews

1076629	1-30-80	1-1-07	2-1-07	2-1-07
0276936	9-1-65	2-10-95	4-23-06	5-3-06
1069742	12-2-64	1-6-07	1-27-07	1-27-07
1079368	11-1-59	4-6-07	4-12-07	4-18-07
1082634	12-24-69	7-31-07	8-1-07	8-3-07

Initial Treatment Plans

10_ _ 893	11-7-51	10-25-07
1084545	12-15-87	10-11-07
1028228	1-11-82	10-19-07
1057208	4-9-61	10-1-07
1036231	2-15-82	11-1-07
8200037	9-30-49	11-3-07
1084774	10-14-71	10-19-07
1021059	12-29-81	10-21-07
1004448	10-3-86	10-20-07
1064382	12-10-61	10-29-07
1080250	5-2-60	10-25-07
1041249	9-5-67	11-3-07
0257158	1-1-47	10-30-07
1084863	7-21-88	10-22-07
1084427	12-31-67	10-24-07

Treatment Team Meetings Attended

0329610 Gero Psychiatrist, Psychologist, RN, CAN, Pharm, RT, Med MD,

CTP		Diet, SW, NP, LME, family by phone
1084971 CTP	AA	Psychiatrist, Psychologist, RN x 2, SW x 2, CAN, Pharm, LME, Mother and Brother
0158906 TPR	P	Psychiatrist, Psychologist, RN, Diet, OT, RT, Pharm, SW, CNA, LME, Brother
0551271 TPR	Deaf	Psychiatrist, Psychologist, RN, DD Specialist, RT, SW, RT Sup, CNA, Interpreter, Mother, Stepfather
1085053 CTP	Adol	Psychiatrist, Psychologist, RN, Teacher, RT, SW, Psychology Intern, LME, CSP by phone, Father, Sister
0274608 CTP	AA	Psychiatrist, Psychologist, RN, SW, PA, Pharm, LME, Med Stu x 3, Power of Attorney, Community Minister

PSR Groups Attended

S (Gero):	Sensory Stimulation	12 patients	4 staff
	Humor Therapy	6	2
	Music Therapy	7	3
P (Rehab):	Wellness for Life	8	2
	Work Group	1	2
	Music Therapy	13	3
	Leisure	4	2
	Life Strategies	10	2
	Emotional Regulation	2	3
	Except. Ed.	2	3
	Exercise Group		
	Inside	5	2
	Outside	4	1
	Engagement/Soc. Skills	8	5
	Functional Skills	6	2
	Workshop	27	6
	Neutral Room	5	1
S (Deaf):	Complex Class	9	5

A (Adult Acute):	Building Social Support	1	0 (at 1:15 p.m.)
	Coping with Stress	3	1
	Non-demand-female	1	0 (observed by hall monitors)
	Using Medications Effectively	9	2
	Building Social Support	10	2
	Practice Facts about Mental Illness	4	2
	Coping with Problems and Persistent Symptoms	4	2
	Coping with Problems and Persistent Symptoms – Substance Abuse	4	1
	Non-demand Room - male	2	1

Exit Plans: US and NC: Broughton Hospital

Assessments

<table>
<tr><th>Item</th><th>Compliance</th><th>Findings</th><th>Comments and Recommendations</th></tr>
<tr>
<td>Appropriateness of the admission
Other less restrictive settings (VIIB)</td>
<td>PC</td>
<td>Recidivism (Rapid Readmission/Repeated Readmissions).
BH is not adequately addressing persons who return after only brief community stays or who accumulate multiple admissions. The facts are provided, but there is no attention/act in the document that addresses this problem.
<table>
<tr><th>MRN</th><th>Document</th><th>DOA</th><th>Unit</th></tr>
<tr><td>0719301</td><td>Treatment Plan</td><td>4-23-07</td><td>PR</td></tr>
<tr><td>0290575</td><td>Psych Assessment</td><td>9-27-07</td><td>AA</td></tr>
<tr><td>1063419</td><td>Psych Assessment</td><td>9-27-07</td><td>Gero</td></tr>
<tr><td>0276445</td><td>Psych Assessment</td><td>9-27-07</td><td>AA</td></tr>
<tr><td>1025228</td><td>Psych Assessment</td><td>9-21-07</td><td>AA</td></tr>
<tr><td>1079214</td><td>Psych Assessment</td><td>9-20-07</td><td>AA</td></tr>
</table>
See Table 1.

Recidivism

Patients with three or more admissions in 2007
(January 1-October 24, 2007)
3 admissions 38 patients
4 admissions 7 patients
5 admissions 1 patient
6 admissions 2 patients
TOTAL 48 patients</td>
<td>BH has seen an increase recently in ED wait times for patients referred to Broughton when BH census is high. The average wait time in March 2007 was 3 hours. This had increased to 9 hours in April and as of May 16 the average wait time for a delayed admission was 12 hours. During May 2007, Ward 105 was housing male patients and 104 was housing female patients. The increased LOS for Ward 104 patients is thought attributable to a delay in transfers to the female treatment wards with high census. The increase in LOS for Ward 4 may be attributable to physician coverage issues during April.

Psychiatric Assessments.
Psychiatric Assessments need work. See discussions of components of the Psychiatric Assessment in this report under Formulation, Initial Treatment Plan, Psychopharm documentation, Recidivism, and Discharge plan.</td>
</tr>
</table>

Multidisciplinary with attention to co-morbid diagnoses, i.e., MRMI and MISA (IIIA1,B1,B5)	*C*	On October 24, 2007, there were 14 MR inpatients per the HEARTS list 8 MR inpatients per the BH SW list From July 1-October 24, 2007, there have been 50 MR admissions admitted to BH Mild 35 Mild-Moderate 1 Moderate 7 Severe 1 Other 6 SA: On the Adult Admission Units: 1) All patients admitted to the Division are assessed for substance disorders. 2) All patients with an identified substance disorder are offered treatment for it at the appropriate time in their hospitalization. 3) Motivation for treatment is assessed at appropriate time(s) in each patient's hospitalization. 4) Treatments offered are consistent with the patient's functional level and motivation for change. 5) Patient's with substance disorders are referred for follow-up substance abuse treatment as part of their discharge plan. Further, the psychiatrist, social worker, and physician extender all conduct individual assessments for substance disorders. The nursing assessment explores the extent of substance use, but does not generate a diagnosis.	
Psychological identifying Suicide risk (IIIB2) Self-injurious behavior risks (IIIB2)	*C* *C*	*Prompts on Psychiatric Assessment, Psychosocial Assessment. Also, "Suicide Risk Factors Supplement." Completed consistently. See #1076614, #1058466, #1076626, #1076625, #1076628.* *Included under suicide risk assessment. Can be noted in Psychosocial Assessment under trauma prompt. Evidence can be picked up under CNA Checklist when scars, bruises and burns noted (which is done in detail – see #1076614,*	

		#1058466, #1076625) and by RN Assessment under Integumentary.	
Cognitive strengths and weaknesses (IIIB2)	*C*	*Evaluated consistently in Admitting Psychiatric Assessment through mental status examination. See #1076614, #1058466, #1076626, #1076625, #1076628.*	
Identify and prioritize patient needs with particular attention to "special needs" Suicide risk (IIIB4)	*C*	*Review of records indicates suicidality and/or SIB assessed on admission, appropriate levels of observation ordered, procedures for changing levels of observation met standard. See for examples: #1078099, #0399500, #1072763, #0280531, #1064695, #0395576, #0287072, #0283819, #0288619, #0714884.*	
Self-injurious behaviors	*C*		
MI/MR	C	MR Patients with a confirmed mental retardation diagnosis are usually referred to one of three PSI pathways in Adult Admissions Division. Individuals who display no psychotic symptoms or on-going behavioral problems, are referred to the Cognitive Disturbance PSI pathway which is designed to service people with mental retardation, TBI, and early onset dementia. Those with active psychotic symptoms are referred to the Disturbed Thought-Low PSI pathway. Patients who find it exceptionally difficult to stay in the group rooms without pacing, going in and out, inhibiting speaking out of turn, and accepting redirection from staff are referred to Group Skills pathway where behavioral demands are minimized and the primary goal is to help patients adjust to the mall environment.	

		In the Psychiatric Rehabilitation Division patients are identified for groups according to their problems (within context of diagnoses) as related to functional impairment, level of cognitive functioning (Level I, II, or III), and level of rehabilitation readiness. Persons with mental retardation can participate in Anger Management, Aquatics, Ceramics, Choir/Musical Instruments, Cognitive Skills, Communication & Interaction Group, coping Skills, Discharge Readiness Basic, Engagement Social Skills Group, Exercise, Functional Skills, Healthy Cooking, Horticulture, Hygiene, Leisure, Living Skills, Medication Education, Motor Group, Music Therapy, News and Views, OT Cooking Basic, OT Crafts, OT Multimedia Basic, Pet Therapy, Pottery Group, Reality Orientation, Rehabilitation Readiness, Reminiscence, Resident Council, SA AA/12 Step program, SA Double Trouble in Recovery, SA Empowering Self-Change, SA Healthy Choices thru Leisure, SA Life Skills, SA Motivational Enhancement, SA Prevention of Relapse, Walking Groups, and Wellness 4Life. Patients on the geropsychiatry wards have cognitive limitations due to various forms of dementia, mental retardation, traumatic brain injury, and/or chronic psychosis. Groups are presented in a manner that is simple and concrete to understand. Groups are repeated several times per week (and moving to a daily schedule) to provide consistency and continuity over the course of treatment for the week. Adolescents who have been identified with mental retardation have IEPs maintained and these patients are offered special education within the Enola School. Adolescent patients with mental retardation have individualized treatment plans	

MI/SA (IIIB2)	C	that contain interventions based on their cognitive limitations, many of which are behavior plans or guidelines. Treatment programming for persons on the Deaf Services unit are designed and implemented for persons with lower cognitive functioning (patients with higher levels of cognitive functioning attend treatment programming in Division A). Co-Occurring (MISA) Disorders PSI Pathway includes 1) Practical Facts about Co-occurring Disorders, 2) Reducing Relapse, 3) Coping With Problems and Persistent Symptoms (Part 1), 4) Coping With Problems and Persistent Symptoms (Part 2), 5) Coping with Stress, 6) Using Medications Effectively (You Are Not The Doctor), 7) Coping with Problems and Persistent Symptoms (Risky Consequences), 8) Building Social Support, 9) Getting Your Needs Met in the Mental Health System. Patients can also access 1) 12-Step Meeting and 2) Motivation Enhancement. Groups specifically designed for treatment of substance abuse in the Psych Rehab Division are: 1) Relapse Prevention, 2) SA AA/12-Step program, 3) SA Double Trouble in Recovery, 4) SA Empowering Self-Change, 5) SA Healthy Choices Thru Leisure, 6) SA Life Skills, 7) SA Motivational Enhancement, 8) SA Prevention of Relapse, 9) Stress Management. Patients on the Deaf Services ADATC unit regularly attend the Co-Occurring Pathway groups provided by the Adult Admissions Division. Patients from this unit attend PSI groups with interpreters to aid in communication. In addition, Deaf patients also participate on their ward in other SA interventions including: 1) Individual assessment and treatment with an LCAS, 2) Individual or Group Education and Discussion according to the MATRIX model of treatment, 3) NA/AA on-ward discussions,	

		complete with books and handouts, and 4) Community based AA/NA meetings (with interpreters). Patients on the adolescent wards are seen for individual substance abuse assessment if this is not clarified during the psychiatric evaluation, typically completed by one of the division's psychologists. Adolescents with co-occurring substance abuse issues are involved in groups where substance abuse issues are addressed, including group psychotherapy, coping with life, self-esteem and social skills. When these adolescents are referred for either residential substance abuse treatment (e.g., Swain Recovery Center), or to intensive outpatient substance abuse treatment.	
Hearing impaired (IIIB6)	*C*	*BH Deaf Services opened on May 1, 2006, with the transfer of 3 long-term patients from the DH Deaf Service. By mid-May, two other deaf patients had been transferred into the service from within the hospital. By June, transfers from other hospitals and referrals brought the BH Service up to near capacity, which is 14, and that is still true as of February 2007.* *Staff* • *9 nurses (all are learning sign), 15 CNAs (3 of whom are deaf, 6 hearing proficient signers, 6 learning)* • *20 hours of physician time; the division psychology supervisor covers deaf services* • *a full-time social worker and a full-time recreational therapist serve patients* • *3 full-time Interpreter positions – Interpreter supervisor (responsible for scheduling and contracting for outside interpreters when needed), 2 interpreter positions (one currently vacant). Contract interpreters when necessary.* • *Program Manager (licensed counselor and*	

		interpreter) *Programming* • *Division A Treatment Mall classes 1015-1130, 1315-1430 Monday-Friday* • *Work Therapy 0930-1130 Monday-Friday (earning $6.15 per hour)* • *Woodworking 0930-1130 Wednesday* • *Group Therapy 1) Community Living-Monday 1300-1400, 2) Anger Management-Tuesday 1400-1500, 3) Symptom Management-Friday 1400-1500 facilitated by the program manager or senior psychologist* • *Recreational Therapy Activities-Exercise groups, social skills group, expressive arts, pet therapy, greenhouse activities between 1300-1500* • *Recreational Therapy does leisure activities from 1530 to 1630 to facilitate nursing staff to change shifts* • *Various evening activities are structured by recreational therapy* • *Saturday-usually an off campus ride to see seasonal sights, activities, swim, or other events determined by recreational therapy.* • *Clinical Addictions Specialist from Division A does an evaluation and weekly substance abuse group* • *Program manager does individual and group therapy in substance abuse.* • *Monday and Thursday night substance abuse patients go to 12 step meetings 1915-2130* *Persons who are deaf have programs specifically established to meet their needs and are "mainstreamed" in groups with deaf interpreters as appropriate. See for example #1064695, #0284801.*	

Psychopharmacological examination of appropriateness of current and ongoing pharmacological treatment for behaviors (IIID6)	PC	Initial Treatment Plan is set out in the Psychiatric Assessment by the admitting psychiatrist. To a very significant degree these are generic statements of no use whatsoever. For example 0290575 (9-27-07). He will be admitted to a secure and supportive milieu and will have complete physical and psychosocial assessments as well as further evaluations by the ward psychiatrist. 1063419 (9-27-07). Clinical assessment by multidisciplinary staff. Pharmacotherapy for psychiatric and medical conditions. 0276445 (9-27-07). Virtually identical to 1063419. 1083493 (9-10-07). I will admit the patient to ward 20, female. Further laboratory and accessory clinical evaluations with treatment interventions on the basis of results. Specific psychopharmacologic intervention versus the patient's mood disorder. Multidisciplinary team evaluation/recommendation/intervention. 1083611 (9-6-07). Virtually identical to 1083493. 1058953 (9-21-07). Admit to the ward for safety and stabilization on level 1. He will get a multidisciplinary evaluation and treatment in the ward milieu. He will also get a substance abuse assessment. It would be nice to get collateral information from his transition house to see why they kicked him out. 1083964 (9-19-07). Virtually identical to 1058953. The initial psychopharm treatment is generally established by the physician who also writes the first orders for psychotropic medications. The initial psychopharm plan is set out in the Initial	

		Psychiatric Assessment. These plans uniformly fail to provide specific rationale for the medications. Stating one is continuing medication the patient took prior to admission is insufficient rationale – in fact, it is not a rational at all. See for examples: 0276445, 1025228, 1058953 (continues addicting medications in a person with significant and active substance abuse), 1083493. Case 1063419 is particularly problematic because the physician continues the medications: olanzapine, trazodone, valproic acid despite diagnosing the patient as having an adjustment disorder. While all Annual Psychiatric Assessments made some mention of medication changes over the course of the year, there was minimal discussion of the reason for the medication selection. Additionally, none of the plans included a complete list of the patient's medications. There is no clear justification for Polypharmacy. 268193 dx: factitious disorder, borderline personality disorder. Treated with nardil and risperidone consta until became hypotensive requiring transfer to medical unit, returned on Aripiprazole. When began refusing Aripiprazole, Clonazepam was tried, but "not helpful", ziprasidone (unclear if also still on Aripiprazole) started, then Fluoxetine because she appeared depressed. Meds given to her by NG tube (seemingly because of non-compliance, but this is not clear). January 2007, based on case conference, a trial of methylphenidate plus weekly Fluoxetine was initiated. 264107 dx: schizophrenia. On lamotrigine 100mg PO BID; haloperidol discontinued in February and quetiapine ordered at greater than FDA recommended dose (acknowledged in dictation) to address irritability, loud speech,	

		in April lithium decreased because patient also on a diuretic. Patient became more hyperverbal and hostile; haloperidol added. 158900 dx: schizoaffective disorder, bipolar type. Patient taking quetiapine, haloperidol, Clonazepam, Valproate; had "a somewhat better year." "Did worse" with medication decreases.	
Medical (VB)	*C*	*History and Physical Exam done on admission. When refused, evidence of return to completion of H&P – see #1076626, #1076625, #1078099, #1050197, #1076256, #0399500, #1076629. AIMS done on admission, as shown by #1076614, #1058466, #1076626, #1076625, #1076628.* *Therapeutic blood levels are generally being done when appropriate.* *#1050197 VPA* *#0275274 Li* *#0287796 Li, VPA* *#363769 VPA* *#1076256 VPA* *#0967706 Li* *#0258630 Li* *Excellent care and treatment note by observation on Medical Service as follows on tour: 1) Dementia, multiple medical problems, verbally aggressive, total care, active medical treatment; 2) Chronic Pain, GSW (1991), paraplegia, catheter, on CO for suicide risk; 3) Dementia, plan to return to NH admitted from, G-tube feeding; 4) Dementia 2^0 alcohol, age 52, G-tube + PO, AODM, intermittent verbal aggression; 5) MR, Psychosis NOS, chronic constipation, volvulous surgery, colostomy, intractable seizure; 6) Li toxicity, ulcer, discharged from BH to NH, readmitted, fracture left hip in fall, S/P hip replacement, AODM; and from review of record, see for example: #101774 (Feb. 14-19, 2007),*	

		#363769 (cardiac work-up), #281903.	

Treatment Plans

Item	Compliance	Findings	Comments and Recommendations
Individualized (IIIA5)	PC	AA Division: Comprehensive Treatment Plans (CTP) are invariably generic, nonspecific, and not really a guide for individualized treatment. Discharge criteria are usually universally true statements – see examples in this section. Interventions are frequently job descriptions (see examples in this section) and individual interventions most often lack duration. Interventions are often only vaguely related to STG's which themselves are not measurable. CTP must be inclusive (or indicate why not). 1077246. Patient has sex offenses and/or predatory behavior, but CTP is silent on this. 1038851. Patient is homeless, has no financial support, but this does not appear as a Problem.	Broughton Hospital indicates it embraces the North Carolina Division of Mental Health's Treatment Planning Model which encompasses six (6) guiding principles as follows: 1) Treatment planning is interdisciplinary; 2) the patient is involved in the treatment planning process; 3) the treatment plan is individualized to meet the patient's needs; 4) the treatment plan is problem-focused; 5) treatment planning is driven by assessment data; and 6) the treatment plan is directed toward the patient's symptomatic relief and discharge. Unfortunately, to date, BH does not adequately execute the principles it embraces. Note: long-range goals define the criteria for the problem's resolution. Short-term goals are small, logical steps that result in reaching the long-term goal(s). Both long-range and short-term goals are written as outcomes that are observable, measurable, and achievable. Initial Treatment Plans (ITP) are so formulaic, are so generic, and lack patient individual focus that it is hard to imagine any staff member ever looks at one after it's written. This is true for all listed in Data Base (these were chosen by BH). The inadequacy of the ITP is especially problematic because this is the architecture of the treatment approach for up to 10 days of hospitalization. Since many patients are discharged with LOS of less than 10 days, this may be the only treatment

			plan.
Interdisciplinary (IIIA5a)	PC	Interventions are performed by staff, not by patients. BH has shown tremendous improvement here. School remains to be brought up to speed; others sometimes lapse. 1083699. Patient will follow requests of staff without becoming angry or aggressive 6 out of 10 times [yes, this is listed as an intervention.] 0259679. Practice flashcards to… Practice communication board 0282366. Will meet with ward psychologist to discuss depression and ways to be more proactive in treatment. 1002350. Patient will talk to staff daily about positive aspects of her life and her positive qualities when depressed at school (used for two STG's). Intervention must be specific, directive and indicate what staff will do. Many interventions fail this (while an increasing number exhibit this – real improvement): 1077246. Prompt patient to attend… 0959273. Provide support… Assist patient with identifying his meaningful roles in life (nursing) Provide patient with positive feedback to encourage feelings of self-worth. 1052689. Encourage patient to participate… 0289693. Redirection as needed for… 1081611. Provide support to patient to ventilate feelings…	

		1070189. Prescribe and monitor the effectiveness of medications for self-injurious behavior. Interventions must be comprehensible to all staff. These examples are written exactly as they appear in Plans: 1083699. YRTP evening group that entails patient to better able limit setting with reacting in an aggressive manner. 1079703. Horticulture to utilize as therapeutic task. Patient has expressed in horticulture. 1071220. Monitor his psychological status – 5 minutes with increased intervention. 0272344. Music therapy to allow music as an expressional outlet to learn to control tone. Team Meetings: S (Gero) 0329610. Interventions were discussed **before** STG's and STG's were presented by discipline, process that virtually precludes interdisciplinary treatment planning. AA 1084971. So much time is taken up by psychiatrist doing an assessment (which should not require Treatment Team context) that there was inadequate time for interdisciplinary work. P 0158906. Good interdisciplinary process. Stood out because this was atypical. Excellent job of redirecting patient so entire Team could stay on track. S (Deaf) 0551271. Most of meeting was psychiatrist interviewing family for collateral data, a process many months overdue. No time for interdisciplinary process	

		S (Adol) 1085053. Meeting was predominantly psychiatrist interviewing patient and talking with father. Through 30 minutes no BH staff other than psychiatrist had said one worked. A 0274608. Meeting lacked any sort of structure. Psychiatrist sought team members input, but most of it was in the name of browbeating the patient. Staff kept telling patient what <u>they</u> would like him to do as if this was a reason he should do what he did not want to do.	
Based on Assessment data (IIIA5a)	PC	In FY '07, Occupational and Physical Therapists completed their annual reassessments at a rate of 33%. Diagnosis Many Comprehensive Treatment Plans do not include all Axis I-V diagnoses; see for example, 1038851, 1061128, 1079703, 1051415, 1083493, 0287691, 0396955, 1035071, 1067019, 1083499, 80200125, 0282366, 1083469, 02887703, 1062469, 1059469, 1082378, 0248342.	
Attend to co-morbid diagnoses (IIIA1, B5)	SC	Much improved. See above.	
Involve patient in identifying goals and objectives (IIIA3)	PC	Patients' Participation 0329610 S (Gero). Patient repeatedly indicated, "Can I go", "Let me out" and "I want to leave now." Patient's problems were not addressed. Rather, team developed <u>their</u> problems for <u>him</u>. Patient clearly indicated that one of the problems the team generated for him was <u>not</u> his problem. This was never addressed. 108491 A. Family perspectives given more credence than patient's perspectives about his life. Proselytizing and pleading were provided more frequently than was	

		addressing patient's needs. Information gathering eclipsed treatment planning. 0158906 P. Patient was active and meaningful participant. Best team meeting of the visit. 0551271 S (Deaf). It would have taken great effort to get this 38-year-old with autistic d/o, ICD NOS, and MR to participants, but no one made any real effort to do so. 1085053 S (Adol). Patient actively participated, but it was in an assessment exercise, not in treatment planning. 0274608 A. Patient not present at the beginning. Patient's goal was "to get out of here [BH] today." This was never directly dealt with. Patient left meeting thinking he was leaving today [confirmed by patient interview after the Team Meeting]. Team wrote the Treatment Plan for this patient after patient was excused from the meeting.	
Involve family/guardian when appropriate (IIIA3)	SC	Family Participation Gero Treatment Planning Meeting (Family by phone) AA Treatment Planning Meeting (Mother, Brother) AA Treatment Planning Meeting (None, but power of attorney and a local community minister came) P Treatment Planning Meeting (Brother) S (Deaf) Treatment Planning Meeting (Mother, Stepfather) S (Adol) Treatment Planning Meeting (Father, Sister)	Efforts to get family members to attend, and success rate of accomplishing this is commendable.
Reviewed and revised as clinically indicated (IIIA5b)	PC	It is really not possible to have meaningful reviews if the Comprehensive Treatment Plan is fundamentally flawed. Per policy, any staff member who has reason to	Reviews observed were information gathering session. This practice needs to be reflected in the reviews

		consider a patient is dangerous to self or others, initiates (or provides for) 1:1 supervision of the patient and immediately notifies the Registered Nurse (RN) on duty. The RN notifies the physician/psychologist immediately. Physician/psychologist makes an assessment and determination as to whether the patient is dangerous to self or others (i.e., suicidal, aggressive and/or vulnerable to harm or falls). If indicated, the physician/psychologist orders the appropriate level of safety precaution. If ordering physician/psychologist is not available to do a face-to-face assessment of the patient at the time of initiation, the ordering physician/psychologist assesses the patient face-to-face within three (3) hours and documents findings in the medical record. Documentation of risk assessment includes written assessment into a patient's medical record, typically in the form of progress notes that go along with written orders. When reducing or discontinuing precautions, the responsible professional documents what factors have changed and/or improved to result in the patient being less vulnerable or at risk for dangerousness to self or others. Patients are not discharged until off suicide and/or aggression risk precautions at least twelve (12) hours. A final risk assessment progress note is written by the psychiatrist on the day the psychiatrist writes the discharge order.	of Treatment Plans.
Treatment Plan Content includes Suicide precautions (if appropriate) (IIIB2)	*NA*	*None required.*	
Measurable behavioral goals and objectives, i.e., basis for quantifying progress (IIIA5a)	NC	Short term goals must be observable, measurable, countable objectives. The STG's almost invariably fail to meet this standard:	Active Treatment: In January 2007 the AA Unit reported it had achieved 20.75 hours of active treatment per week per patient. This ended a PI project. However, since the treatment process is not individualized on AA, and STG's are not

		0382950. Patient will make only statements based on factual situations or experience during conversation with staff. 1077246. Learn to meet new people while at BH that are a positive influence. Patient will learn 5 skills to assist him in remaining sober… Patient will talk about his probation requirements and verbalize… Patient will learn to verbalize appropriate boundaries in relationships. 0959273. I will develop and practice relapse prevention. Identify and implement coping skills and mechanisms to make me feel better 1083212. Will recognize that some of his beliefs were not based on reality and that he needs treatment. 1030253. I will consider medications which can help me abstain from alcohol. I will experience a decrease in hallucinations. 0276445. I will pay attention in group for 30 minutes. 0719301. Patient will manage incremental changes in free time without overuse of caffeine, smoking… 1052689. I will talk with staff as often as necessary when feeling angry or frustrated without becoming aggressive for the next two weeks. 0282763. Develop and implement four emotional regulation skills. Will identify three triggers that lead to aggressive behavior. Will be compliant with medications.	stated in observable, measurable, countable terms, the groups provided cannot represent "active treatment."

		0259679. Will communicate needs through communication board. Will dress correctly… 1081880. When patient gets upset with others, he will tell staff about this rather than take matters into h is own hands. Patient will be able to allow others to speak in turn without interrupting. 0395419. Participate in all aspects of treatment milieu to learn about options for treatment. 1070189. I will identify and practice at least three ways to prevent future hospitalizations. 1051415. When talk about feelings of anger and abandonment as an alternative way to acting out. 1027652. Will start to eat, participate in activities and keep clean. 0287691. Patient will state three things she can do when is angry. 0287691. Patient will identify five specific things she needs that she thinks will help her have a successful placement in the community. 0396955. Patient will learn and practice three independent living skills (cooking, money management and hygiene/grooming while at BH. 1035071. Patient will (a) not appear to be experiencing hallucinations or delusions; (b) not display disorganized or assaultive behaviors; (c) learn strategies to manage his stressors; (d) learn social skills to help him operate successfully in the community. [There are four different STG's].	

		1067019. Patient will state three socially acceptable ways to get his needs met. 0717230. I will identify what led to this admission. 0717230. I will work with my social worker to identify and secure placement. 0282366. I will identify and practice three ways to take care of myself. 1002350. Patient will explore, with staff, coping skills to determine effective strategies to deal with hallucinations. 1002350. Patient will list positive personal qualities to remind herself daily. 1027652. Will start to eat, participate in activities and keep clean daily. 1027652. Arrange placement at X group home. 1062469. Patient will participate in daily exercise opportunities for the rest of her hospital stay. 1082378. Patient will understand his mental illness and manage it optimally. 1082378. Patient will be able to tell staff about his response to medication and if he has any side effects from it. 1082378. Patient will receive repeat capacity evaluations as warranted.	
Emphasis on teaching alternative adaptive behaviors (IIIA6)	PC	Interventions should not be job descriptions: Nursing: staff will monitor for suicidal ideation and intervene quickly and consistently to keep patient safe (1083212). Nursing: Assess effectiveness of medications (1030253). Nursing: Administer X as prescribed on	

		monitor for effect (0719301). Nursing: Obtain vital signs weekly s ordered and monitor parameters and report (0719301). Psychology: Monitor progress toward goals on behavior plan (1052689). Medical MD: Liaison with psychiatrist regarding med/treatment review (1083699). Nursing: Observe patient for unsafe behavior (i.e., aggression) and intervene early to provide safety for patient and others (1081880). CEA Facilitator: Music Therapy Group for the purpose of using music to express his emotions (1081880). Psychology: Create BIP plan and provide incentives for positive behavior choices and review/revise as necessary (1083139). Nursing: Document aggressive episodes (1083714). Social Work: Talk with patient regarding where he may want to reside or can reside after discharge and bout continuing treatment (0395419). Psychiatrist: Mental status exam weekly to assess for effectiveness (1059992). Social Work: SW will provide patient's case manager information to assist with locating placement and correspond with her regularly to arrange disposition for patient (0259679). Psychologist: Psychotherapy to discuss concerns that she may have about her mental illness and other issues as identified by her (1079703). Nursing: Teach patient to follow BH program to help her succeed (1083493). Nursing: Medication education is to teach	

		patient in being knowledgeable about his medications (1083493). Nursing: Observe/report side effects of administered medication (1074350). Social Work: Meet with patient 5-10 minute sessions to assess for needs. Allow patient time to ventilate feelings and provide supportive feedback (1071220). Social Work: Work with patient to secure appropriate placement before discharge (0719230). Nursing: Medications per order (0717230). Psychiatrist: Conduct mental status evaluation to assess effectiveness (1083469). Social Work: Meet with patient for 5 minute sessions and allow him time to ventilate feelings or express concerns. Nursing: Teach patient to follow BH Adolescent program to help her succeed (1002350). Nursing: Monitor effectiveness of medication (1027652). Nursing: Nurse will educate patient regarding medications (0287703). Nursing: Observe and report response, side effects of medication (1062469). Social Work: Social Worker will facilitate visits to identify community placements (1062469). Psychiatrist: Talk with treatment team members about their observations of patient's symptoms and response to treatment – for purpose of determining diagnosis and which medications are most appropriate for him (1082378). One Annual Psychiatric Assessment (268193) mentions instituting a behavior plan over past year,	

		does not note interventions or target behaviors and notes the behavior plan yielded no change. One (1030209) lists pet, recreational, music, and occupational therapy, but gives no details and does not tie this to target behaviors. In 3 other summaries, there was no mention, or very vague mention of teaching alternative adaptive behavior. Examples: 158900 Plan "An effort will be made to decrease paranoid accusations and hostile affect." 264107 Plan "angry outbursts require a locked facility."	
Identified least restrictive interventions (IVC)	NC	Thinking in treatment Plans is much too limited – see above. 0276445 9/27-11/2/07 9th admit, last 4/17-4/28/05 Set fire to own home and series of neighborhood mailboxes. CTP Problem: I. Ms S reports that people have been after her since she was 14-years-old II. Chronic back pain… III. Hypertension No attention anywhere to firesetting. Not dealing with high risk behavior.	
Explanation of psychopharmacological interventions with particular attention to the prescription of Benzodiazepines (IIID6)	PC	In a few Treatment Plans, absent from most.	
Antipsychotic medications	PC	In some Treatment Plans, not in others.	

(IIID6)			
Criteria for use of seclusion and/or restraint as last resort (IVC)	N/A		
Criteria for release from seclusion and/or restraint (IVF)	N/A		
Education about diagnoses (IIIC2)	SC	Often included in Treatment Plan.	Execution and outcomes are not clear.
Skill building for Problem-solving techniques (IIIC1)	PC	Each intervention, including group interventions, need to be specific for the individual in addressing one STG. The purpose of the group is not relevant to each patient's Treatment Plan. As an example of useless and confusing verbiage, note the following for 1061128 under one STG (which is typical): • PSI #9, Recovery Strategies – Wrap-UP – For the purpose of establishing a lifetime habit of bringing closure to the events of the day, reflecting back on the goals set that morning, and progress made toward recovery. • PSI #9, Recovery Strategies – Meet Your Treatment Team – For the purpose of increasing communication between treatment team members and patients, in order to reduce the stress of hospitalization and improve quality of treatment. • PSI #9, Recovery Strategies – Goaling – For the purpose of establishing a lifetime habit of planning the day, encouraging the patient to set goals that are measurable, realistic, and related to treatment. • PSI #8, Getting Your Needs Met In The Mental Health System – For the purpose of learning how to take care of my mental health.	Treatment Plans are not directing interventions aimed at skill building – see Treatment Plan section. Some skill building takes place by chance, but there is little way to communicate this from one staff to another. Behavioral Plans are early efforts at skill building. Worksite could be used as location for skill building, as could groups, but this must be directed by skill building STG's specific to each site/activity.
Self-medication skills (IIIC3)	NC		
Symptom management (IIIC4)	PC		
Cognitive and psycho-social skills (IIIC5)	PC		
Moderation or cessation of substance use (if appropriate) (IIIC6)	SC		

Medical treatments (routine, preventative, emergency) (VB)	C	• PSI #7, Coping With Problems And Persistent Symptoms – For the purpose of establishing a lifetime habit of planning the day, encouraging the patient to set goals that are measurable, realistic, and related to treatment. • PSI #6, Coping With Stress – For the purpose of establishing a lifetime habit of planning the day, encouraging the patient to set goals that are measurable, realistic, and related to treatment. • PSI #5, Reducing Relapse – For the purpose of establishing a lifetime habit of planning the day, encouraging the patient to set goals that are measurable, realistic, and related to treatment. • PSI #4, Using Medications Effectively – For the purpose of establishing a lifetime habit of planning the day, encouraging the patient to set goals that are measurable, realistic, and related to treatment. • PS #3, Building Social Support - For the purpose of establishing a lifetime habit of planning the day, encouraging the patient to set goals that are measurable, realistic, and related to treatment. • PSI #2 – The Stress Vulnerability Model And Strategies For Treatment - For the purpose of establishing a lifetime habit of planning the day, encouraging the patient to set goals that are measurable, realistic, and related to treatment. • PSI #1, Practical Facts About Mental Illness For the purpose of establishing a lifetime habit of planning the day, encouraging the patient to set goals that are measurable, realistic, and related to treatment. *Disease-specific medical plans found consistently.*	

Transition/Discharge planning that reflects the need for aftercare services (IIIB5c, VIIB1)	PC	The first set of discharge criteria ("discharge planning starts on admission") is set out in the Initial Psychiatric Assessment. These criteria are uniformly such general statements or impossibilities as to approach being meaningless. For example: 1083493 (9-1-07). The patient will have no suicidal or homicidal ideation. The patient will have been started on appropriate medications and will have received a good initial therapeutic response. A good follow-up plan will be in place. 1058953 (9-21-07). Ensure absence of suicidal ideation. 0290575 (9-27-07). He will receive maximum benefit of symptom stabilization while in the hospital setting and will have an adequate aftercare plan in place, particularly one that will permit the continuation of clozaril if this is resumed and proves to be beneficial for him. 0276445 (9-27-07). She no longer exhibits any dangerous behavior. Improvement of her psychosis. 1025228 (9-21-07). Absence of aggressive behavior. 1083964 (9-19-07). Ensure absence of suicidal ideation. Appropriate plan for disposition. SA treatment. 1079214 (9-20-07). Ensure absence of suicidal ideation, improved mood. 1063419 (9-27-07). No longer exhibits dangerous behavior towards herself or others. Improvement of her judgment. Improvement of her psychotic condition. Discharge CTP Discharge criteria/plans on the CTP need to be accurate and specific rather than general	Lack of specificity. Patient leaves with plan to develop a plan. LME reps present (good), but they do not assist team to develop a plan.

		statements of principal or ethos or universally true: Patient will have a place to live and an identified plan for post-hospital recovery (1030253). (Deaf patient) No suicidality or homicidality; appropriate placement; absence of aggression (0282763). (Severe MR) No physical aggression for three days; appropriate disposition and follow-up (0259679). (13-year-old) No danger to self or others (1088139). Absence of psychotic symptoms; absence of any aggressive behaviors; residence adequate to meet needs (0289693). No evidence of danger to herself and improvement in psychosis (1061128). BSW is responsible for patient discharge plan. Currently he was unable to identify his discharge plan at this time (105992). Patient will be discharged to a less restrictive setting when stable. SW will evaluate with patient, family and treatment team and mental health what type facility is appropriate… Patient will require nursing level of care upon meeting his discharge criteria. SW will coordinate discharge planning with family and LME. Appropriate aftercare services with mental health follow-up will be arranged for patient at time of discharge (1083714). No access to articles that would engage patient to kill himself while in detention. Appropriate disposition and follow-up (1051415). Not dangerous to self or others. Stable mood and affect (1083493). No more delusions; stabilize depression (1027652).	

		Absence of imminent danger to self or others, compliance with prescribed medication regimen; acceptance of realistic discharge placement and plan (1067019). Stable mood and affect with resolution of her psychosis (1083499). Stabilization of psychosis; development of an Aftercare Plan; continued absence of homicidal/suicidal ideation (8200125). No physical aggression for 14 days. No verbal threats of aggression for 14 days. Improved mood control. Appropriate disposition and follow-up (1056943). Not dangerous to self or others. Stabilized mood and affect. Control psychotic symptoms especially auditory hallucinations (1002350). No more delusions; stabilize depression (no more crying); doing ADL's; stabilize physical complaints (1027652). Comply with medication. Absence of severe mood swings that interfere with ability to live outside the hospital. Discharge placement that meets her needs (0287703). Patient will have stabilized behavior (e.g., no agitation or suspiciousness) such that she can be placed in a less restrictive community placement (e.g., nursing home) (1083501). Reduction in psychotic symptoms and agitation sufficient for him to be managed in a community setting (0382950). Case examples: 0977822, age 29-years-old with diagnoses I. Polysubstance Dependence, II Borderline Personality Disorder. 2007 hospitalizations 3-15 to 3-21	

		3-21 to 4-18 ADATC 5-11 to 5-18 5-23 to 6-5 7-15 to 7-20 7-20 to 8-10 ADATC 8-12 to 8-17 8-22 to 10-3 36 admissions 1997-2007 6 ADATC 30 BH In 2007, spent 70/203 days out of hospital or 66% of time in hospitals with longest hospital stay = 42 days. But: 1. Recidivism not listed as a problem 2. Recidivism not a focus of Treatment Plan 3. No focus on community life/community treatment/advantages of staying out of hospital on treatment plan. Last discharge to **shelter** after 42-day hospitalization 1033322 Dx and medication use. Admission Dx: MDD with psychotic features or Bipolar with psychotic features Discharge Dx: Cocaine Dep Alcohol Dep Psychotic 2^0 SA Mood Dis 2^0 SA (Discharge Diagnoses) But prose says R/O malingering; R/O lying about auditory hallucinations to save face. Rx'd in BH with risperidone 1mg bid for two days than discontinued. Doing well.	

		Discharged on risperidone PRN (?). Why PRN? He needs it or he does not! Need closure on dx's. Dispositions: "He is going to try to get back into the Salvation Army after working for a day to pay the bill that he owes them there." 1004448, age 20-years-old with first BH admission at age 13, is diagnosed with I. Bipolar Disorder NOS and II. Borderline Personality Disorder. History of 18 NC State Hospital admissions, 17 of them at BH. In 2007, admissions as follows: DDH 1-12 to 1-17 BH 2-9 to 2-22 BH [3-2-07 was denial] BH 4-5 to 4-13 BH 5-26 to 6-1 BH 6-27 to 7-2 BH 7-6 to 8-6 BH 8-28 to 10-4 Last three BH admissions followed periods of community tenure of less than 30 days each. Formulation is silent on repeat hospitalization, i.e., 6 BH admissions between February and August 2007. Treatment Plan – does not have recidivism as a problem. Focused on one issue, i.e., first 3-4 days out that is not the problem per the data. Discharge criteria: "Stable mood and affect with resolution of symptoms especially self-injurious behaviors." But this patient has in all likelihood not been in this state since prior to puberty and may never be.	

Policies

Item	Compliance	Findings	Comments and Recommendations
Ensure patients with "special needs" are appropriately evaluated, treated and monitored Suicide risk (IIIB4) Self-injurious behaviors MI/MR, MI/SA (IIIB2) Hearing impaired (IIIB6)	*C* *C* *C* C	Per policy, any staff member who has reason to consider a patient is dangerous to self or others, initiates (or provides for) 1:1 supervision of the patient and immediately notifies the Registered Nurse (RN) on duty. The RN notifies the physician/psychologist immediately. Physician/psychologist makes an assessment and determination as to whether the patient is dangerous to self or others (i.e., suicidal, aggressive and/or vulnerable to harm or falls). If indicated, the physician/psychologist orders the appropriate level of safety precaution. If ordering physician/psychologist is not available to do a face-to-face assessment of the patient at the time of initiation, the ordering physician/psychologist assesses the patient face-to-face within three (3) hours and documents findings in the medical record. Documentation of risk assessment includes written assessment into a patient's medical record, typically in the form of progress notes that go along with written orders. When reducing or discontinuing precautions, the responsible professional documents what factors have changed and/or improved to result in the patient being less vulnerable or at risk for dangerousness to self or others. Patients are not discharged until off suicide and/or aggression risk precautions at least twelve (12) hours. A final risk assessment progress note is written by the psychiatrist on the day the psychiatrist writes the discharge order.	*Excellent requirement: After the first use of emergency restrictive interventions, the dangerous behavior can no longer be categorized as unanticipated. A modified treatment plan becomes necessary to prevent or eliminate dangerous behavior. When incidents of ERI occur, information is relayed to the treatment team for possible treatment plan modification. The treatment team leader is responsible for reviewing the incident anaylsis and the current treatment plan for needed modification. This should take place as soon as possible but no later than the next scheduled morning rounds/treatment team meeting.*
Reduce the use of forced	*C*		*Note: "The use of more than one antipsychotic at*

intramuscular medication that differs from the patient's prescribed oral medication (IIID4b)			*a time should be avoided."* *Note procedure: "A pharmacist reviews each medication order before dispensing the medication. If there is an order for concomitant use of psychotropic drugs in the same therapeutic class or an order for a dosage above the recommended maximum, a pharmacist contacts the physician using a memorandum designated for this purpose and by telephone if the situation requires immediate attention. The memorandum serves as a reminder to the physician to adequately document in the chart the rationale for using more than one psychotropic drug in the same therapeutic class or rationale for using a dose above the recommended maximum."*
Use of restraints or seclusion (IVA,D)	SC	A full survey was conducted from 8/22/07-8/25/07 to follow-up on the outstanding immediate jeopardy (IJ) identified on 8-2-07. Based on survey findings, the immediate jeopardy of 8-2-07 was not abated and was determined to be ongoing as evidenced by the following: The facility staff failed to provide qualified staff for the monitoring and supervision of an agitated patient with known unsteady gait and failed to ensure the assessment, evaluation and modification of treatment plan for an agitated patient with known unsteady gait to prevent reoccurrence of harm and a fall requiring transfer to an acute care hospital and subsequently tertiary care hospital for one of one sampled patients with a known unsteady gait; the hospital's governing body failed to assure systems were in place to ensure assessment, evaluation and modification of treatment plan for the same patient; failed to ensure medical staff accountability and oversight for the quality of care; failed to oversee coordination of medical staff; failed to enforce medical staff bylaws/hospital policies to ensure physician completion of the medical record within 30 days	This appears to be an exception.

		after discharge and failed to ensure an organized nursing service. The hospital's nursing staff failed to meet patient care needs; failed to update the nursing care plan and failed to assess a change in condition prior to emergency transfer and upon return to the hospital. Plan of Correction by BH includes: 1) key policy changes made as reflected in changes to CPM 4-10 "Emergency Restrictive Intervention Policy", effective July 2, 2007; 2) the new concept of the possibility of using a transport board; 3) Walkie Talkies to assist communication efforts of the Mediation Team in an emergency; 4) Incident Analysis form implemented by Nursing Administration; 5) funding for a North Carolina Intervention certified trainer to become certified as a Crisis Prevention Institute certified trainer; and 6) to add training to improve the staffs' response to prevent or to respond to emergency psychiatric situations involving escalating or full scale physically aggressive behavior as well as how to safely apply manual restraints to a patient on the floor and to establish carries/techniques to take a patient from the floor to a restraint room.	
Use of PRN psychotropic medications (IVB)	*C*	*Policy requires: "Medication orders are accompanied by documented justification, either in progress notes or on physician's order sheet."*	*CH statement: Concurrent use of more than one anxiolytic is generally discouraged. This includes the use of anxiolytics for other purposes, such as to prevent withdrawal, sedation/hypnosis, and muscle relaxation. Continued use of anxiolytics for greater than one month is often not necessary. After such time, a trial off of anxiolytic medication should be considered. Anxiolytic medication should be withdrawn carefully.* *This should be reviewed and perhaps strengthened. Consult with Cherry Hospital about eliminating use of PRN psychotropic medication orders altogether.*

Individuals with health problems are identified, assessed, diagnosed, treated and monitored	SC	Plans for routine and preventive care were not discussed in the Annual Psychiatric Assessment and were not part of the plans. For one patient (268193) there was mention of treatment on the medical floor for hypotension.	

Procedures

Item	Compliance	Findings	Comments and Recommendations
Health problems (identified, assessed, diagnosed, treated and monitored) (VB)	*C*	*See Assessments Section.*	
Investigating untoward events, serious injuries, and sentinel events (V1A2)	PC	Sentinel Event Evaluations do not start early enough in the sequence of events. See, for example, Sentinel Event analyses for deaths listed in Data Base.	CMS: When a hospital is found to be out of compliance with one or more Condition of Participation, and immediate or serious threat to patient health and safety exists, a determination must be made that the facility no longer meets the requirements for participation as a provider of services in the Medicare program. Such a determination has been made in the case of Broughton Hospital and, accordingly, the Medicare provider agreement between GH and the Secretary of the Department of Health and Human Services is being terminated. This termination will be effective August 25, 2007. CMS's findings: Based on hospital policy and training manual reviews, closed medical record reviews, hospital investigative report review, personnel file reviews and staff interviews the hospital's Governing Body failed to assure effective systems were in place to ensure the safe application of manual restraints of a patient on the floor; the hospital failed to protect the rights of a patient in manual restraints on the floor; the hospital failed to provide supervision by a registered nurse trained in the use of manual restraints of a patient lying on the floor; including continuous monitoring of the patient's condition;

			the hospital failed to have a policy or procedure for the safe and appropriate manual restraint of a patient on the floor; the hospital staff failed to continuously monitor the health status of a patient in manual restraints; the hospital failed to implement safe restraint techniques; and the hospital failed to ensure staff were trained in the application of manual restraints of a patient on the floor.
Routinely reviewing incident reports to assess individual or systemic trends or issues exist and changes in treatment are warranted (V1A3) Investigating untoward events, serious injuries, and sentinel events (VIA2) Routinely reviewing incident reports to assess whether individual or systemic trends or issues exist and changes in treatment are warranted (VIA3)	*C*	See Table 2.	

Practices

Item	Compliance	Findings	Comments and Recommendations
Case formulation (IIID6)	PC	Comprehensive Treatment Plans do not contain formulations. Psychiatric Assessments do contain formulations. Doing it in this fashion is not a problem. The inadequacy stems from the fact that the psychiatrists' formulations are much too limited and do not integrate significant information they themselves have included in the material they report from their interviews. For example, missing from the formulation:	

		1063419 (9-27-07). Serious suicide attempt with GI consequences from lye injection; husband died from AIDS 1083493 (9-10-07). 12-year-old on 5th psych admission; Hx includes physical abuse, removed from mother at age 8, alcohol use, runaway episode, not enrolled in school 10833611 (9-6-07). Untreated prostate cancer 1025228 (9-21-07). Consider malingering, but readmitted to get out of placement patient thought was too expensive. 1058953 (9-21-07). Admission stimulated by drug seeking; significant hx of physical and sexual abuse; witnessed considerable violence in childhood 1083964 (9-19-07). Significant physical and mental abuse by husband she started dating at age 12, married at 18, divorced at 22; two children, ages 4 and 3 she is failing to take care of In 1081611, compare the meager formulation with material included in the Premorbid Functioning section: Biopsychosocial Formulation: This is a 17-year-old female with strong genetic predisposition for mental illness given family history and severe psychosocial stressors. She presents with chronic depression, mood disturbance and borderline personality traits. Premorbid Functioning: She was born and raised in New York where she lived with her mother and grandparents. She has lived with various different family members for sometime. She was raped by her father and was taken out of his home. She has been in foster care since that time. She has not been in school since about the 8th grade. Her mother	

		died 6 years ago (patient age 11 years old).	
Monitored, documented, and reviewed by qualified staff (IIID1) Use of anti-psychotics Medication combinations Pro re nata (PRN) and STAT orders (IIID2)	PC PC PC	No. of patients on antipsychotic medication, October 24, 2007 = 251 Patients on two or more antipsychotic medications as follows: 2 atypicals 1 patient 1 typical + 1 atypical 36 patients 2 typicals 50 patients 3 antipsychotics 10 patients TOTAL 97 patients Percentage of patients on antipsychotic medications who are on two or more = 39% Case Example 1076629 26 year old, increased BP, 4 lipids About 10 hospitalizations in Columbia SC Psychosocial Assessment – completely inadequate; no evidence of attempt to get collateral information, patient poor historian; no attempt to contact hospital in SC. Initial Treatment Plan is inadequate CTP Dx: Schizophrenia, Undif type Criteria for Discharge: Absence of psychotic symptoms. Return to baseline level of social or cognitive function [except no one knows what that is]. Absence of dangerous behavior. [No real dangerous behavior PIA – peeping in windows.] Without measurable STG's = cannot monitor improvement. CTP under old format is close to useless.	On call MD should be able to write STAT orders, but not PRN orders.

		MD Orders 1/1 Risperidone 2mg BID at admission 1/3 Depakote ER 1000 Ambien 10 prn insomnia 1/3 Haldol 5+ Benadryl 50+ Ativan 2 po now 1/3 Close observation – vulnerable to harm 1/5 Haldol 5 now 1/5 Risperidone 2-4=6 Benadryl 100 HS 1/9 Manual restraint 1/9 Manual restraint 1/9 Haldol 5+ Ativan 1+ Benadryl 50 q 8 hrs prn for A/A/Psychosis 1/10 Risperidone consta 37.5 IM on 1/15 & q 2 wk Depakote ER 1500 1/12 CPZ 50-100 = 150, then on 1/15 CPZ 100-200 = 300 1/15 Manual restraint → ITO → Seclusion → 4 point restraint 1/16 CPZ 150-300 = 450 1/16 on 1/19 CPZ 200-400 = 600 1/16 Haldol 5+ Benadryl 50 q 8 hrs PRN psychosis/agitation. IM back-up 1/17 Haldol 10 + Benadryl 100 PO NOW. IM back-up. 1/17 4 point restraint 1/18 D/C CPZ. Zyprexa 20 hs 1/20 Ativan 2mg + Haldol 5 + Benadryl 50 now 1/21 Manual restraint → ITO 1/24 Haldol 5 + Benadryl 50 q 8 hrs prn A/A for 30 days. IM back-up 1/30 Treatment Team agrees patient can have a haircut 1/31 Risperidone 2 tid = 6 2/1 Patient died No Attending note 1/19-1/30! CTP: 1-5-07 TPR due 1-24-07	

		TPR done 1-30-07; does not reflect patient's course in the hospital at all; does not discuss use of involuntary interventions; has no attention to behaviors and establishes no behavioral goals, has no interventions for psychiatry, has job descriptions for nursing, Social Work, lists all groups as one Mall intervention, includes no medications and is basically unrelated to this patient's problems and needs! Also, patient simultaneously on 1. Risperidone 2. CPZ 3. Haloperidol then 1. Risperidone 2. Olanzapine 3. Haloperidol No adequate explanation on TPR or in progress notes
Intramuscular injections (IIID5) Benzodiazepines (IIID2)	*C* PC	Total number of patients on standing orders for benzodiazepines (10-22-07) 75 No. on for alcohol withdrawal 2 No. on for seizures 2 No. of psychotropic reasons 71 Percent of total census on standing orders for benzodiazepines 23% Examples of Documentation in Table 3: • 0272620 • 1038851 • 1043425 • 0278514 • 1054739 • 0395576 • 1081880 • 1084285 • 1083528

Other		• 1059992 • 0382950 • 1081611 • 0259679 • 1079703 • 0953726 See Table 4 and 5. There is a failure to use maximal doses before combining with a second antipsychotic and a failure to explain why not if there is a clinical rationale - see Table 6. Per policy, Physician Progress Notes on Division A Acute Stabilization Wards, for Stay 2 days: At least two documented psychiatric reviews (which may include an initial psychiatric assessment and a discharge progress note); for Stay 3 days: At least three documented psychiatric reviews (which may include an initial psychiatric assessment and a discharge progress note). If longer stay on these Wards: At least x 3 weekly (which may include an initial psychiatric assessment and a discharge progress note). First 60 days on Other Wards: Weekly (q 7 days) notes. After 60 Days, writes notes every 14 days. BH reports significant increase in adverse drug reactions (ADR) from warfarin, lithium, clozapine, and oxycarbamazepine.	These notes must not only meet this frequency, but must meaningfully contribute to the patient's assessment and treatment (all aspects). Does this represent improved reporting of ADR's or actual increase in ADR's? If the latter, what is the explanation?

Protocols

Item	Compliance	Findings	Comments and Recommendations
Nursing protocols for medical care and treatment (VC)	*C*		*Note the requirement, per NP No. 1-44 (Patient Education): Patient teaching reflects the individual needs of the patient/family as*

			determined by [the Registered Nurse] assessment process, and is consistent with current prescribed treatment and goals (italics added).
Nursing protocols to ensure that patients are appropriately supervised and monitored (VIB2)	*C*	*Hourly checks (on the hour) and a minimum of eight random checks are conducted in each 8-hour shift when patients are not in the Treatment Mall/School. The random checks occur at least once between each hourly check and are recorded on the Patient Monitoring Record. During operating hours of the Treatment Mall/School: The monitoring of patients and their status and the documentation of such is the responsibility of staff assigned to the Treatment Mall/School (e.g. rosters, schedules, and psychosocial intervention notes) except for those times that nursing staff resume responsibility for patient monitoring (e.g. meals, homeroom, transport to and from the wards).*	

Plans

Item	Compliance	Findings	Comments and Recommendations
Appropriate evacuation plans (VIB3)	*C*	*Hospital Evacuation Plans from BH Emergency Operations Plan: Emergency Evacuation Worksheet for Full Facility Evacuation; Emergency Evacuation Route maps for all wards currently in use reviewed and found to meet requirements.*	

Physical Plant

Item	Compliance	Findings	Comments Recommendations
Modifications for hearing impaired (IIIB6)	*C*	*Deaf ward has wide open hallways and painted light colors; did appropriate repairs; installed flashing doorbells to the ward and building, flashing fire alarms on the hall, and strategically placed mirrors at ends of halls and on corners;*	

		installed signs to give directions to ward, warn of deaf pedestrians, and to identify offices and entrances; placed 10 TTYs strategically around the hospital; TTY pay phone on ward; 2 videophones – one in program director's office, one on ward; connected the emergency transmitter system to flashing blue light on the ward with a box that identifies where the emergency is; provided each ward staff an emergency transmitter (ET) button that fastens to his/her person; installed 2 captioned TVs and purchased a variety of captioned videos; supplied pocket talker amplifiers and 2 different listening systems; purchased American Sign Language/Deaf specific games, posters, videos, books, stamps, dry erase boards and communication board system.	
Eliminate to a reasonable degree all suicide hazards in patient bedrooms and bathrooms (VIB1)	C	Gero Ward 15 BR: stall doors partitions laundry chute door handle door hinges shower control shower bench one toilet plumbing sink plumbing Bedroom: sink plumbing locker hinges commode rails Bathroom Monitoring for Patient Safety Record completed through 9:00 am when patients went to Mall P-Division Ward U Shower room: Handicap rails Pipes for showerheads Cover for water controls Inner doorknob Tub faucet	Structural hanging risks are mitigated by a system of random checks that are documented by direct care staff. Documentation was checked and found to be up-to-date.

		Metal shelving Sprinkler head Bathroom: Stall door Brackets that mount stall walls Metal uprights for stall walls Handicap rails Sink plumbing Bedroom: Partitions Locker hinges Electric boxes (5′ from floor) Sprinkler head Main door hinges Ward V Bedroom: [all singles] Electric box Locker door, hinges Shower: Tub – Handicap rail Faucet Sink - plumbing Faucet Plugged pipes for shower head Main door – inner handle Bathroom: Urinal Handicap rails Stall door handles Stall wall supports Sink plumbing Sink faucets Ward R Bathroom: Stall door Stall wall Stall door handle Upright supports Handicap rail Sink plumbing Sink faucets Ward R Bathroom: Stall door	

		Stall wall Stall door handle Upright supports Handicap rail Sink plumbing Sink faucet Electric switch (8′ from floor, reach by standing on toilet) Shower room: Tub faucet Industrial sink Sink plumbing Sink faucets Electric switch Water control door Curtain rod support Handicap rails Locker door handles Bedroom: Single – Lockers Inner door handle Multiple – Partition Lockers Electric conduit Deaf Services Ward 22 Parker Building Bathroom – locked except when patient requests and staff supervises from the hall Shower – same as bathroom. Only one patient at a time. Bedroom – locked Adolescent Ward 20 Bathroom – locked 24/7 Shower – locked 24/7 Bedroom – all singles; if double-up due to overcrowding, room is staffed A Division Ward 4	

		Bathroom – Toilet ok Stall door Stall support Stall walls Stall door knob Sink plumbing Sink faucet Shower head Shower faucet Handicap chairs Bedroom: Nightstand rails Locker Door hinges Door knob Ward 3 Bathroom – same as Ward 4, plus toilet plumbing.	

Staff Training

Item	Compliance	Findings	Comments and Recommendations
Writing behavioral goals and objectives (IIIA3)	PC	Outcomes of training evident in Treatment Plan section.	Substantial efforts have been made (BH is commended for this), but results remain fair at best.
Serving the needs of patients requiring specialized care (suicide risk (IIIB4)), SIB, MI/MR, MI/SA (IIIB2), Hearing impaired (IIIB6)	*C*		
Risks and side effects in administering benzodiazepines	*C*	On October 30, 2007, Dr. April Fulbright, Pharm D, Clinical Pharmacist, Broughton Hospital presented "Benzodiazepines: Judicious Prescribing" as a Continuing Medical Education Program.	*Add some material about benzodiazepines to Nurse Aide I Training Program: Anxiety*
Risks and side effects in administering antipsychotic	*C*		

medication			

Specific Documentation Requirements

Item	Compliance	Findings	Comments and Recommendations
Behavioral goals and objectives which include, when possible, patient and family input (IIIA3)	C	Behavior Intervention Plans (BIP) show marked improvement. The process now involves a 1) functional behavioral assessment (documented in most cases); 2) a plan with a) behavior management plan, b) reinforcement plan and c) tracking plan; 3) behavior tracking form or data sheet; 4) staff training plan with sign-in sheet and 5) reference to the BIP in the patient's Treatment Plan as an intervention for specific short-term goal(s).	BH is commended for the significant improvements it has made in behavioral interventions. The BIP's and the role of the psychologist, which both now appear in the Treatment Plan (excellent) should become more specific and individualized (rather than the general statements that currently appear in most plans).
Treatment plans shall reflect an interdisciplinary process based upon reliable objective data and clearly established measurable goals (IIIA5a)	PC	See Treatment Plans section.	Cannot document process that is not occurring.
Use of all medications (IIID1)	SC* PC*	Psychopharm Documentation. 1021059. Admitted 10-21-07. Psych med changes 10-22 and 10-24. Most changed without progress note. Only rationale for 100mg quetiapine is insomnia at patient's request. That is not a rationale in an incompetent (has a guardian) MR patient, or any other patient for that matter. 0279075. Admitted 10-19-07. Dx: Psychotic D/O, Mild MR. Two antipsychotic medications ordered on admission without explanation in progress notes (may be in admission note). Quetiapine dose increased by 50% on fourth hospital day with no progress note. 1004345. Admitted 10-15-07. Dx: Schizophrenia, Mild MR. Patient transferred from CH on two antipsychotic	PI project reports required documentation for psychotropic Polypharmacy improved quarterly from 43% and 32% in the first and second quarter to 91% and 100% in the third and fourth quarters. This does not parallel any findings. The differences might be that one was a quantitative review and one was a qualitative review. The same may hold true for the review of documentation requirements where medications are initiated, changed and discontinued. The required number of physician progress notes (see other section under Practices and section below) improved in a similar pattern, i.e., the second half results were much better than the first halves.

		medications and one benzodiazepine. There is not one psychiatrist note 10-16 to 10-24 that comments on medication despite a medical event that should have necessitated a review of psych meds.	*Documenting use gets SC; documenting rationale for use gets PC.
Identify the symptoms and/or behavioral problem and tie to justification for the use of any antipsychotic medication or benzodiazepines (IIID4)	PC	MARS are not adequate documentation for nurses and do not replace progress notes. See Table 7 for an example from one patient.	Per policy, medication orders are accompanied by documented justification, either in the progress notes or on the physician's order sheet. BH is not following its own policy. Per policy, Physician Progress Notes on Division A Acute Stabilization Wards, for Stay 2 days: At least two documented psychiatric reviews (which may include an initial psychiatric assessment and a discharge progress note); for Stay 3 days: At least three documented psychiatric reviews (which may include an initial psychiatric assessment and a discharge progress note). If longer stay on these Wards: At least x 3 weekly (which may include an initial psychiatric assessment and a discharge progress note). First 60 days on Other Wards: Weekly (q 7 days) notes. After 60 Days, writes notes every 14 days. These notes must not only meet this frequency, but must meaningfully contribute to the patient's assessment and treatment (all aspects). BH reports significant increase in adverse drug reactions (ADR) from wanfarin, lithium, clozapine, and oxycarbamazepine. Does this represent improved reporting of ADR's or actual increase in ADR's? If the latter, what is the explanation?
Clearly document behavioral issue(s) and tie to justification for use of intramuscular medication (IIID5a)	*N/A*	*NC statute allows IM administration of medication for oral refusal of medication without the requirement of the demonstration of behavioral requirements/emergency. Hence, a patient can receive an IM medication for a thought disorder absent any behavioral manifestation.*	

Use of restraints and seclusion documented and reviewed in a timely fashion by qualified staff (IVE)	*C*	*Documentation of procedures followed when using seclusion or any form of restraint was found to be exactly as it should be with one single exception. Proper documentation was ascertained based on review of:* *0392763 2/15* *0291198 2/15* *1017774 2/21, 2/28* *1004499 2/22 (twice), 2/21 (twice), 2/20 (twice)* *1077647 2/27* *0399500 2/26 (3 X), 2/25* *0967706 2/18* *1076103 2/07* *1064695 2/21, 2/19, 2/17* *0395576 2/24, 2/13* *0287072 2/23, 2/13* *The exception was #1053540 for two episodes on 2/23. Documentation was fine for 2/17 and 2/16. The exception has heuristic value.* *While the section of the Seclusion/Restraint form is being completed indicating Treatment Team Review, it appears to be done in a pro forma or cavalier manner. Most often the "no revision" box is checked. Other times there are remarks like "consider a BIP" written time and again on the same patient.* *Examination of Patient Incident Reports showed: S/S are cross-referenced on Patient Incident Reports as they should be.* *Manual restraint, even if only for one minute, is recorded (with physician evaluation and order completed for each observed in chart review).* *When manual restraint precedes a more restrictive intervention, each is recorded and documented.*	*The RN must record on the physician order from the time the order was orally received, not the time the MD showed up and wrote the order.* *If a higher level of restrictive intervention is required after an order for a lesser level of restriction has already been given in writing, the MD must reassess and reorder the higher level of restrictive intervention. Hence, a second written order and second written evaluation.* *Consider setting thresholds that, when met, require a CTP modification or written justification as to why no revision is thought necessary.*
Criteria for release from restraints and seclusion clearly identified and written in patient's treatment plan (IVC)	*C*		

		Manual restraint is most often 1-2 minutes.	
Provisions of nursing and medical care (VD)	PC	See Table 8. Review of Records for LA (1083155) Case Overview LA is a 44 year-old female, admitted 8/18/07. The admission note refers to an 8/15 ICU admission for lithium toxicity (minimal detail about admission) prior to this inpatient psychiatric assessment. Review of additional records reveals that the patient was referred for psychiatric assessment because they feared she was unable to care for herself in the community. The community hospital discharge summary is available and provides additional detail not in the psychiatric admission note. LA was admitted to the ICU on 8/15/07 with a lithium level of 3.14, confusion and hyperreflexia noted. Her level declined to 2.52 at 24 hours and was last measured at 1.41 on the day of her discharge, 8/17. She was hypokalemic (2.4) at admission; this was corrected. Her renal function remained normal. EKG showed QT prolongation during her ICU stay. While in the ICU she received IV hydration. Also, to address agitation, which was judged to have mania and psychosis, over the course of these three days quetiapine was titrated to a dose of 300mg PO BID. She also received parenteral lorazepam (amount not clear; ordered 2mg IV q 2 hours prn agitation). At discharge, the note comments that her lithium level should normalize in 24 hours. She was admitted to Broughton Hospital on 8/18 and is described in the psychiatric admission note as confused with unintelligible, rapid, dysarthric speech, oriented to hospital and responding to (but not stating) her name. Ataxia is also noted. The diagnostic	*Comments* The most concerning part of this case is her initial admission. The admission note uses working diagnoses of psychosis and mania without mention of delirium in the differential diagnosis and without any history of the patient's past psychiatric functioning. In spite of her confusion and ataxia, she is continued on quetiapine, a new medication to her at a moderately high dose. Multiple now orders are given, including risperidone which could cause orthostasis and lorazepam and diphenhydramine which could contribute to her confusion. There are no notes justifying these choices or reflecting any examination by a physician. Despite her discharge for lithium toxicity with a lithium level of 1.4 the day prior, labs are not ordered, nor do notes reflect that prior lab work has been reviewed. It is also somewhat concerning that multiple falls occurred before the patient was placed in a geri-chair and it seems that she was allowed to return to ambulation and within that day sustained a serious fall. Also of concern, after the patient's fall that resulted in a laceration above her left eye, the PA's exam note states that the patient had a normal gait and noted normal coordination that seems inconsistent with all other notes. At her re-admission, it is unclear why she is started on risperidone and prn Alprazolam. The working diagnosis at that point seems to be a primary psychotic or manic disorder. There does not seem to be mention of delirium from medications or from head injury mentioned as possible contributors. Nursing notes are consistent in describing an improving and eventually steady gait and no falls are documented. There is frequent documentation of the constant observation staff member remaining within arm's reach. I did not

		impression provided reflects mania/psychosis with no mention of delirium in the differential diagnosis and no mention of how recent medical events and medication additions could contribute to or cause this state. The duration of these symptoms, their similarity to or difference from past exacerbations, and how this compares to her baseline are not described. Admission orders include strict precautions for falls and continuing the quetiapine started at the local hospital. No labs are ordered nor are the results of the labs and EDG fro the outside hospital mentioned. The events of 8/18 and 8/19 reflect increasing agitation, consistent ataxia with falls, and consistent confusion. Nursing note on 8/18 at 10:00 a.m. state MD ordered risperidone 2mg and diphenhydramine 50mg PO now (no note from the MD). She continues to be disoriented and hyperactive. At 0005 LA is described as pacing, picking at the air and the floor. On 8/19 she was noted to be unsteady and feeling dizzy. Positional vital signs showed a stable blood pressure and an increase in heart rate from 83 to 100 from supine to standing. On 8/19 at 0915 again an MD ordered risperidone 2mg and diphenhydramine 50mg PO now (no note from the MD). At 1130, she received lorazepam 2mg. Nursing notes then reflect that the patient stumbled on untied shoestrings into a wall bumping her left orbit resulting in a ½ inch laceration. The PA is called and examines the patient. This note reports a normal gait, normal strength, coordination, and sensory perception with a normal cranial nerve examination. The note does not reflect a differential diagnosis for the gait problem. At 1300 LA received zyprexa zydis 5mg. Nursing	find any clear indication that this observation was insufficient. The patient does consistently report headache and hearing loss and little commentary is included in the chart about the likely etiology of these complaints, with the exception of one RN note that refers to headache as potentially being the result of her initial fall. This includes the PA note that does not give a differential or working diagnosis for the headache. The neurological examination in this note is limited given this patient's history of recent, significant subdural and intraparenchymal bleeding. There is no indication that the possibility of further bleeding was considered and the notes do not comment on the possible etiology of the ecchymosis behind the patient's ears. There is also no documentation of calls to a neurology or neurosurgery consultant regarding these headaches; presumably the team attributed the headaches and hearing loss to the prior injury and did not consider the possibility of progression of the bleeding. The team does follow the discharge recommendations from the hospital and completes the follow-up head CT which in the end leads to this patient's treatment.

		notes from 8/19 describe multiple falls resulting in ecchymosis despite the patient being on a 1:1. She was placed in a gerichair for some parts of this day. At 1445, LA fell and hit her head in the occipital region. She was examined by the PA who noted a "palpable collection" in the occipital area. LA was transferred to Grace Hospital for further evaluation. There, a CT scan showed a subdural hematoma and one area of intraparenchymal hemorrhage. She was admitted to the ICU, incubated and observed with neurochecks. Neurosurgery recommended non-operative management. A follow-up CT scan on 8/20 revealed no further bleeding. She was extubated without incident and returned to BH on 8/24. At admission, she was placed on strict precautions with the 1:1 to stay within arms reach. LA was started on risperidone 0.5mg PO BID and Alprazolam 0.5mg PO BID prn agitation. Throughout this second admission, almost all nursing notes comment on her gait and reflect a gradual improvement; by 8/30 all notes refer to a steady gait. She is first reported to have pain behind her ears and neck on 9/2.07. She received acetaminophen and the nursing notes reflect that the PA was called to see the patient. On 9/3 she reports pain in her right ear and hearing loss. Bruising is noted on the right side of her neck. The PA is notified and examined the patient. The PA's note documents pupil reactivity, intake extraocular muscles and "no visual or hearing deficits." Her fundi were not visualized. No further neurological examination is documented and the bruising on her neck is not noted. There is commentary on the differential diagnosis for her headache or hearing loss. This	

		notes/suggests continued acetaminophen. The psychiatrist's note records a MMSE on 26/30 and says that the patient reports being comfortable walking and not feeling unsteady (no examination of her gait is noted). The nursing notes then refer to continued complaint of headache on 9/9-9/11/07. No falls are reported and her gait is described as steady. On 9/13, Clonazepam 0.5mg PO BID is added for anxiety. A follow-up head CT had been recommended at discharge from Grace Hospital. On 9/13 the PA orders this CT and it is completed on 9/14. The Internal Medicine note on 9/14 reports receiving a call from a radiologist that the hematoma expanded and is now of a size that it can be drained. The radiologist's report states that the hematoma now covers much of the right cerebral hemisphere and, in addition to the one area of intraparenchymal hemorrhage seen prior, 4 additional areas of intraparenchymal hemorrhage are seen. She is sent to her neurosurgeon for evaluation. Later on 9/14 she was admitted and underwent right frontal craniotomy and drainage of the hematoma. A follow-up CT 72 hours later showed re-accumulation and she returned to the OR for a second evacuation. LA left this hospital AMA on 9/24. She was not re-admitted to BH.	

Quality Assurance and Performance Improvement

Item	Compliance	Findings	Comments and Recommendations
Detect timely and adequately problems with the provision of protections, treatment, services and	*C*	*Per BH policy, BH has a Patient Safety Program encompasses a system-based hospital-wide approach to foster a safe environment by integrating safety priorities/approaches into*	

supports and to ensure that appropriate corrective actions are implemented (VIA1) Actively collecting data relating to the quality of nursing and medical services (VIA1a) Assessing data for trends (VIA1d) Initiating inquiring regarding problematic trends and possible deficiencies (VIA1c) Identifying corrective action (VIA1d) Monitoring to ensure appropriate remedies achieved (VIA1e)		*relevant hospital processes, functions, and services. The program involves proactively identifying the potential and actual risks to safety, identifying the underlying cause(s) of such risk and making the necessary improvements so risk is reduced. It also establishes processes to respond to serious incidents, critical events, and sentinel events, identifying causes through root cause analysis, and making necessary improvements. BH provides immediate response to errors including care to those affected, containment of risk to others, and preservation of information for subsequent analysis after immediate medical care (if applicable) is provided. 1) The Patient Incident Report is completed and faxed within two hours to the patient safety manager and other designated managerial and administrative staff. 2) Incidents are entered into the computerized incident reporting database. Information is aggregated and trended and presented to Performance Improvement Function Committee and other entities as outlined in the Performance Improvement Plan. Actions are taken based on findings. 3) The patient safety manager routinely reviews Safety and Health Committee reports, Infection Control reports, Performance Improvement data, clinical measurement and assessment activities, staff and patient reports/surveys, code reviewed, Medical/Psychology Staff committee minutes/recommendations and utilization management data to identify actual or potential risks and actions taken to minimize risk. Medication variances are trended and analyzed by the pharmacy director, nursing administration and clinical services director, as appropriate, then reviewed by the Pharmacy and Therapeutics Committee. Relevant data and plans of correction are reported to the Performance Improvement Function Committee quarterly. Nursing*	

		administration, pharmacy director and clinical services director are responsible for implementing immediate corrective actions, if indicated. 5) Suspected adverse drug reactions are documented on the Suspected Adverse Drug Reaction Reporting Form. Adverse drug interactions are trended and analyzed by the Pharmacy and Therapeutics Committee and reported to Performance Improvement Function Committee by the pharmacy director. Corrective actions are implemented. 6) Sentinel events and serious incident/occurrence notification are immediately posted on a secure e-mail notification system. 7) A "Patient Incident Report/Serious Incident Analysis Form" requires an investigation by the division director (or department director, if applicable) or designee and begins as soon as possible (or immediately, if indicated) and is submitted to the patient safety manager within three days. 8) The analysis requires a description of the facts of the incident, investigative findings and recommendations/immediate plan of action. Environment of Care Function Committee and Safety and Health Committee issues related to the physical environment and staff injuries are monitored by the safety director. The safety director provides reports to the Safety and Health Committee and Environment of Care Function Committee who in turn recommend corrective actions to minimize risk. Information related to safety management of the physical environment and staff injuries is also reported to the patient safety manager, and, through the safety director, to the Performance Improvement Function Committee. 9) Sentinel and serious incident/occurrences are reported to the hospital director/CEO or designee. The hospital director's office notifies designated staff in the State Operated Services Section of DMHDDSAS and the Office of Public Affairs. 10) Information relating	

		to the RCA and corrective action plans is disseminated by the chief of regulatory compliance to Leadership, Medical/Psychology Staff Executive Committee and others as applicable. *Analysis of Performance Improvement Data (see Data Section of this report) substantiates compliance.*	
Conducting adequate mortality reviews to ascertain the root causes for all unexpected deaths (VIA4)	*C*	*Reviewed: Death Review #20729825, RCA #42, Mortality Review Committee minutes June, July, October 2006 and January 2007. Medical Record review of death undergoing sentinel review. All indicate process within standards at this time.*	*Shows improvement from earlier evaluation.*
System to oversee discharge process (VIIB3)*	PC	The Aftercare Plans have serious problems. 0276445. Physician's aftercare instructions to patient (PAIP) is only a good will gesture; the Discharge Progress Note (DPN) does not account for two antipsychotics. 1058953. PAIP is a good will gesture; DPN fails to explain quetiapine dose of 1200mg; diagnoses on Aftercare Plan (AP) and on DPN are not the same; no follow-up appointment with psychiatrist; no explanation for discharge person who abuse multiple substances on a benzodiazepine. 1084250. No follow-up appointment with psychiatrist; PAIP suggests SA Rx "when ready" (?). DPN says no medication, but order sheet indicates doxepin (14-day supply provided). 1084507. No follow-up appointment with psychiatrist; PAIP provides no real information to patient; TBI patient provided oxycodone for four days, then what does he do(?) – needs to be stated. 1076744. PAIP is good will gesture; no explanation for fluphenazine PO and depot + second antipsychotic (outpatient psychiatrist need to know rationale which should be on	Also, see recidivism date in Assessment section.

		DPN – in this case there is no note at all. 0259684. No psychiatrist aftercare appointment; PAIP is useless statement. A better DPN. 0276286. No psychiatrist aftercare appointment; Social Work statement reads like standard paragraph with fill in the blanks. 1084963. No psychiatrist aftercare appointment; SA treatment "when ready for patient only treated for SA is puzzling at best; discharging patient with one diagnosis of "benzo abuse" on a benzodiazepine requires explanation. 1085000. No psychiatrist aftercare appointment. 1085047. No psychiatrist aftercare appointment. PAIP not really helpful; need explanation for disulfiram dose at 750mg; no progress note of any kind on day of discharge. 1085087. No progress note of any kind on day of discharge; otherwise, better than others. 1085044. No psychiatrist aftercare appointment; better than others. Similar findings on others listed in Data Base section.	

Communication

Item	Compliance	Findings	Comments and Recommendations
Physician orders for enhanced supervision be communicated to appropriate staff (IIIB4b)	*C*	*See Safety Precautions, CPM 3-19.* *In review of all cases, and throughout tours, no exceptions found.*	
Treatment team members communicate and collaborate effectively (IIID7)	PC	Annual Psychiatric Assessments range from adequate (0278606, 0264101) to puzzling (0268193) to poor (1030209, 01588900). For 0268193, why would the psychiatrist/treatment team sustain inpatient treatment for a 48-year-old with Axis I diagnosis of factitious disorder with psychological and physical complaints and Axis II diagnosis of borderline personality disorder when the literature reports that such patients regress and do poorly with prolonged inpatient stays. All	

		Annual Assessments need to improve the "psychiatric service plan" section. The certification statement needs to be designated yes or no since at least one of these assessments states the patient does not need hospital level of care.	
Adequate and appropriate interdisciplinary communication among relevant professionals (VE,VI)	PC	PSR Progress Notes almost invariably fail to meaningful record progress toward a specific STG. Staff write general statements, attendance comments too nonspecific to be useful even when attendance is a component of a STG, patient's stated goal with no relevance to any treatment objective. Comment "progress toward goal" without specifying what progress is not helpful. Examples of PSR progress notes all from one patient (0276445) with STG: "I will pay attention in group for 30 minutes." "to have a good day" "to stay out of trouble" "sat in corner" "Pt was quiet. Made few contributions to group" "Listened, smiled, acknowledged her name" "Pt was attentive and alert. She did not verbally participate. Progress toward goal." "Met her goal." "Pt partially participated in groups" "to be organized" "STG in progress" "looking around room" and scores more of the same ilk	

Staffing Requirements

Item	Compliance	Findings	Comments and Recommendations
Ensure a sufficient number of qualified staff to supervise suicidal patients (IIIB4b)	*C*	*100% of the time a staff person is added to the ward staffing for any ordered 1:1 coverage.*	

<table>
<tr>
<td>Hire and deploy sufficient number of qualified direct care and professional staff, particularly psychiatrists and nurses, necessary to provide patients with adequate supervision and medical and mental health treatment (VA)</td>
<td>NC</td>
<td>Number of days admissions have been closed (for any part of the day) due to 110% rule from initiation through August 31, 2007:

<table>
<tr><th>Month</th><th># of Days in Month</th><th># of Days Patients on Hold</th><th>Percent</th></tr>
<tr><td>February</td><td>28</td><td>10</td><td>35%</td></tr>
<tr><td>March</td><td>31</td><td>12</td><td>39%</td></tr>
<tr><td>April</td><td>30</td><td>8</td><td>27%</td></tr>
<tr><td>May</td><td>31</td><td>17</td><td>55%</td></tr>
<tr><td>June</td><td>30</td><td>21</td><td>70%</td></tr>
<tr><td>July</td><td>31</td><td>20</td><td>65%</td></tr>
<tr><td>August</td><td>31</td><td>20</td><td>65%</td></tr>
<tr><td>Totals</td><td>212</td><td>108</td><td>51%</td></tr>
</table>

Staffing
BH has had an average daily census decrease from 437 in FY ’00 and FY ’01 to 316 in FY ’07. That is a 28% decline. Total admissions, however, have actually increased slightly from 3828 in FY ’00 to a low of 3202 in FY ’03 to a peak of 3910 in FY ’07. Staffing cannot be based on census alone, but must consider the admission and discharge rates.

By oral report, since last evaluation visit and as of 11-6-07:
Psychiatrists
Lost 3.5 FTE
Gain 1.3
Net – 2.2
Psychologists
Lost 2.0
Gain 0
Net – 2.0
Social Work
Lost 5.0 (2.0 within last 2 weeks)
Gain 1.0
Net – 4.0</td>
<td>BH, with assistance of DMHDDSAS needs to improve recruitment and retention of professional staff. If this means salary differentials, additional perks, modified work week, job shares, increased educational/conference/CME time, etc., then NC must do this. If such changes require modifications of policy, regulation and/or statute then NC must do this. There have been other states that have made such interventions as I have suggested above (and others) to recruit and retain professional staff at more “remote” locations.</td>
</tr>
</table>

Psychiatry Positions with Ward Coverage
November 5, 2007

Name	FTE	Ward Coverage	Coverage per FTE
Campbell	1	U,V	42
Chung	0.5	105 (x 2 weeks)	42
Dudley	0.5	T ½, W (0800-1200)	27
Frasca	1	3, 6	28
Gaworowski	1	4	15
McCuen	1	104, Admitting	14
Mohiuddin	1	14, 15	30
Northam	1	18, 22 ½	20
Schmitt	1	20, 22 ½	18
Sebastian	1	S, T ½	33
Walsh	1	8	17
Wheeler	1	7	13

Psychiatry to patient ratio is not workable at this time.

If you should have any questions about this report, please feel free to contact me by telephone at 508-856-6527, by fax at 508-856-3270, or via email at jeffrey.geller@umassmed.edu.

Respectfully submitted,

Jeffrey Geller, M.D., M.P.H.

JG:vab